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WOMEN'S MOTIVATION FOR FAMILY PLANNING IN
KISII DISTRICT: POTENTIALS AND BARRIERS

By

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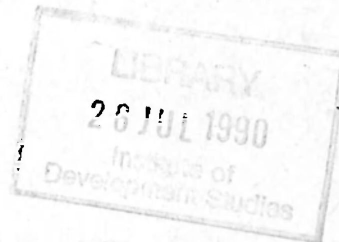

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By

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ABSTRACT

This paper is tentatively arguing that women in Kisii District are confronted with a number of factors which are acting both as potentials as well as barriers to their motivation for family planning.

Focus is put on progressive and regressive changes in female status and role at the household level. Factors such as changing sexual division of labour, changing gender relations and gender roles and changing decision-making pattern are discussed as well as the way in which these changes are interacting positively or negatively on women's motivation for limiting their childbirths and making use of family planning.

As men and their attitude to family planning seem to create a major barrier for many women, research on men was included in the study, and their attitudes are tentatively discussed. Other factors interacting with women's motivation for family planning are considered to be value and costs of children and fears of side-effects. Also availability and quality of family planning services are discussed. It is argued that a number of potential users are lost because of inadequate services.

INTRODUCTION

The aim of this paper is to discuss factors which are acting both as barriers as well as potentials for women's motivation for use of family planning services in Kisii District, with focus on factors on the household level. The discussion is based on some preliminary findings of "A Socio-Economic Study of Women's Utilisation Rates of Rural Health Services and Family Planning Services in Rural Areas of Kenya", a project at present being carried out in Kisii District.

The study is linked 1) to the present strengthening of existing rural health strategy in Kenya, where women's health including family planning is central, and 2) to the present concern with Kenya's rapid population growth. Focus is put on the profound discrepancies that exist between utilisation rates of antenatal services and family planning services, family planning being used to a very limited extent. As research carried out in connection to this project forms the basis for this paper a brief outline will be given of the study.

PROJECT OUTLINE

The study is designed to explore and analyse reasons supporting the differences in utilisation of services. Linked to this, the aim of the study is to develop a knowledge about the barriers that prevent women from using the services, barriers that exist within the services themselves as well as barriers external to the services, but which are an integral part of society. Consequently, a main objective of the study is to locate the area of conflict for women and to pinpoint the factors crucial for an improvement of the services, in particular family planning. It should be emphasised that the study is not stressing the issue of family planning for population control. This is outside the framework of the project.

The project is interdisciplinary, in the sense that it is carried out by two researchers from different disciplines, social anthropology (the author) and medical sociology (Alanagh Raikes)+). It is at the interface of these two disciplines that the research is located, i.e. factors

+) The findings discussed below are findings made by the author during the first research phase. The discussion is mainly dealing with factors at the household level.

linked to the household level as well as factors linked to the health services are both studied in order to establish a more differentiated understanding not only of barriers but also of possible potentials for improved use of the services.

The objectives of the studies at the health service side are to assess the distribution of health services and family planning services in Kisii District, and to investigate to what extent they are used+). Socio-economic status of the clients are being studied together with quality of services and personnel, interaction between health staff and clients, costs and distances from the services.

At the household level, objectives for the studies are to assess the interaction between changing female status and role, changing sexual division of labour, changing gender roles, changing decision-making pattern and women's motivation for and use of ante natal, and in particular family planning services. Factors such as women's access to resources, social networks, cultural beliefs, and costs versus value of children are explored. Important factors also to be investigated are women's knowledge, attitude and practice in relation to ante-natal care, spacing of births and family planning.

RESEARCH FRAMEWORK

A crucial factor most often left out of this type of research is women's status and role at the household level, and the way in which status and role interact with women's use of health and family planning services. Data collected at the health services, in particular family planning services, indicate that there are a vast number of serious barriers to use. However, they are not considered sufficient to provide a comprehensive explanation, and a central hypothesis of the study is that what has to be explored are the various dimensions of women's status and role within the household, with emphasis on sexual division of labour, changing gender roles and changing decision-making patterns - and their effect on women's fertility patterns and motivation for family planning.

+) The study started out to look at the health services as such, but after the initial phase of the study, focus has been limited to include only preventive services, i.e. ante natal and family planning services.

The central hypothesis is based on the fact that during the process of commercialisation in Third World economies there has been a considerable shift in the sexual division of labour, resulting in drastic alterations of the male and female roles.

Women have become increasingly involved in agricultural production, including cash crops, and tasks previously undertaken by men have become the responsibility of women, in addition to their traditional tasks. This, it has been argued by several studies, has resulted in two opposite trends, 1) an intensified subordination of women and control over female labour by males, and 2) a lessened social control over women by individual males, leading to an increasing independence for women.

Linked to these trends, it has also been argued (Edholm, Harris, Young, 1977, and Young, 1978) that when there is a high level of correspondence between the gender system and the sexual division of labour, women generally accept their subordinate roles. However, when changes in the productive process bring the gender system into contradiction with the sexual division of labour, when there is no longer congruence between the two, then women generally do not accept their subordination. This will be reflected in women's perception of themselves, their position in production, etc. and in particular in the decision-making between spouses. This,it is argued by the above authors, given the potential for change.

On the basis of this theoretical approach, and provided with the conceptual tools developed within the framework of this approach our study should reach a more profound understanding of some crucial factors which are acting either as barriers or potentials for women's use, in particular family planning. Other factors, which are considered of major importance for women's motivation and influencing their use patterns, are costs of children,fear of side effects of contraceptives, traditional beliefs combined with factors linked to inadequate information, distance to the services and lack of availability of services.

PROFILE OF STUDY AREA

Kisii District in Nyanza Province has been selected as study area for a number of reasons: Kisii is the district in Kenya with the highest population growth rate, approx. 8%. As to population, it is now approaching

1.5 mill. Population density is also one of the highest in Kenya, varying from 200-600 per square km (with an average of 304 per sq. km.). Consequently, a study of Kisii District is likely to indicate both present and future trends for use of health and family planning facilities, which may be of importance for the future planning of these services not only in Kisii but also in other areas in Kenya. In terms of health facilities, Kisii is, to day, an area with average distribution of health centres and dispensaries. In terms of family planning, Kisii is characterised as an area of "low acceptance".

The bantu-speaking Gusii tribe constitutes the vast majority of the population, and our studies only includes this tribe. Kisii is one of the most fertile areas in Kenya, and the rural economy is characterized by emphasise on maize, finger millet, beans, peas and sweet potatoes as the main crops. Bananas are now also a well established part of the crop complex. Tea and coffee are important cash crops. A variety of vegetables are cultivated mainly for own consumption/or sale in local market.

Kisii farmers are increasingly being faced with land pressure because of population growth, and average holding are less than 2 hectares. Traditionally, a typical farm consisted of a long strip of land running from the top of a ridge in the hilly highland and down towards the valley bottom. Now, however, with the increased population growth and the continuous dividing of land among sons/or selling of land in order to get cash, the original long strips of land are being increasingly divided into a number of enclosed separate plots, and land which is fertile is getting more and more exhausted because of intensive use.

RESEARCH METHODOLOGY

Research on the health services is concentrating on assessing distribution and quality of the services. In addition utilisation patterns are studied, and barriers to women's use are looked at.

At the household level in-depth studies are being carried out. Women are selected according to the following criteria (which are overlapping each other): Users of family planning and ante-natal services and drop-outs of both services, in particular family planning. Criteria related to socio-economic background, and whether it is a female headed

household or not are also taken into account. All women are cultivators on small holdings, in addtion to their traditional tasks as housewives.

A questionnaire survey is also in the process of being carried out at the household level, covering 1) aspects linked to the health services 2) aspects linked to women's knowledge, attitude and practice in relation to using the services as well as 3) aspects linked to the household level. In this survey, the WHO guidelines for random sampling is used in a modified version. 35 clusters (20 interviews from each cluster) randomly distributed in the 5 divisions of Kisii Qistrict should provide us with a reliable coverage of Kisii District. All questionnaires are being coded for programming.

In-depth studies of men are also being carried out. In addition mini-questionnaires for men has been developed, addressing men with some of the same questions that women are asked, with focus on family planning issues. This questionnaire, which is used ad hoc, will be analysed qualitatively.

PRELIMINARY FINDINGS: Tentative analysis of factors acting as potentials and barriers to women's use of family planning*)

Sexual division of labour within the household

Traditionally, women in Kisii were brought up to value their roles of wife, mother and cultivator. There was a very clear sexual division of labour which was again reflected in a very pronounced role separation between males and females. This was manifested in two separated hierarchies. The masculine hierarchy was administratively responsible for the family's interests, i.e. land and cattle. This included apportioning land for the various women of the homestead to cultivate, cattle for the males to marry with and conducting disputes or lawsuits. The male family head, together with his sons, was also responsible for safeguarding the well-being of all family members.

The feminine hierarchy was responsible for the food-producing cycle, for general domestic services, procuring firewood and water, for tending and training young children and nursing the sick, for helping to keep good relations with neighbours and kin, etc.

*) In this discussion women's use of ante-natal services will be left out as ante-natal use does not seem to create the same constraints for women, and besides, are widely used in comparison to women's use of family planning.

These two clearly defined hierarchies made gender roles distinct, as these were closely linked to the very clear sexual division of labour. This traditional hierarchy has been submitted to profound changes in the present Kisii.

All women in our sample are cultivators on small holdings and depend on their livelihood on the land. Size of plots varies from ½-6 acres, with average on 1-2 acres. In addition to their traditional tasks such as providing and preparing food for the family, fetching water, collecting firewood, washing, sweeping, taking care of children, hoing, weeding, smearing, maintenance of the houses they are also digging, planting, weeding as well as sometimes ploughing and clearing the land. In addition, if they have cattle, they milk the cows and often take them grazing. They grow maize, millet and wimpy mainly for own consumption as well as vegetables, which they sell in the market. Some of them are also growing cash crops such as tea and coffee.

Men's duties and work tasks are easy to define in theory - but not in practice. During the field-work carried out from 8-4 o'clock, only a very few men seemed to be around. Only a minimal number of men who lived permanently on the farm were contributing with their labour input. During the above hours of the day we would always find the women working around the house or in their shambas, unless they had gone to the market, and we would always be interrupting them in a work process.

If the women were not present, their children or neighbours would know that the mother had gone to fetch water, gone to the market or to the posho mill etc. - When we asked the women about their husbands whereabouts (i.e. if they lived permanently on the farm, and had not migrated for work) 3 standard answers were given 1) he has gone drinking, 2) he has gone to the market to meet friends or 3) he has gone to visit relatives or friends. Most often the first answer was given. Only a minority of women had husbands who had an employment, and contributed with money.

Access to and control over resources by women

The social, political and ideological system on which Kisii society is founded and functioning today is - in spite of continuously being submitted to changes - still based on male dominance and male superiority. This is

reflected in women's access to and control over resources. According to research made by Achola Pala (Discussion Paper No. 218/IDS, 1975) between 4-5 per cent of farm land in Kisii was in 1975 registered in the name of women. However, in our sample we have not yet come across any women who have land registered in their own name. This could be explained by the fact that the women interviewed are in their reproductive age, and therefore too young to have acquired any land on their own. Consequently, all women were depending on their husband as to use-right to land.

The women do not own livestock either, livestock belongs to men, but as with land, women have use-right. They milk the cows to get milk for their children or they sell the milk, and sometimes keep the money for themselves. Chickens belong to women, and they trade them in the market and sell eggs.

As to control over other resources, women are in control of money from the sale of their produce, mostly vegetables, sold in the local market. As to coffee and tea, payment is most often issued in the name of the husband in spite of the fact that he often never has contributed with labour in the picking of these crops.

Mechanisms of control over women: Bride price and Circumcision

Bride price - or dowry plays a crucial role, inspite of the fact that an increasing number of married women never were paid for, or never will be paid for, neither in cows, nor in cash. The serious shortage of land in Kisii has resulted in hardly any grazing land left for cattle and lack of cash.

However, the institution of bride price is found to be an important mechanism of control by males over women. If a husband has paid bride price, his wife is his property. He can dispose of her as he wishes. He owns her labour, her produce and her children. It is his right to beat her (whether or not bride price is paid) if she is not "obedient".

If a woman wants to divorce her husband, this is almost impossible. In that case the husband can claim that the cows (and/or cash) are given back by his parents-in-law. The latters would, most probably not

have any cows left in their possession (having given them to their marrying sons). Consequently, women - being the property of their husbands ("we are just bought like cattle") have no choice but to stay with their husbands. Husbands, however, if they are not satisfied with their wife and knowing that anyway they would not be able to claim their cows back, prefer to keep their wife as a labourer to cultivate their land - and take a 2nd wife.

In spite of the controlling effect of bride price, it also constitutes a means of stability and security for women, - and it is strongly interacting with women's concept of themselves and their self respect, in the sense that a woman paid for feels that she is worth something. In our in depth studies many women have expressed that if bride price was paid for them they could at least go back to their parents and "stay away a while" if they had been too badly beaten up by their husbands, and he would have to take care of the children during their absence. If bride-price is not paid, women have no measures of sanction against their husbands. He has no responsibility towards his children, and he can send both wife and children away any time.

As to circumcision - or rather clitoridectomy of young girls this is a clear measure of control by males over women, the purpose of which is as it functions nowadays - for women to be in control of themselves, sexually+). Our findings indicate that, circumcision is an institution which is not much debated neither by women nor by men. On the contrary, it is a "must" which is accepted by both genders. When asked, women would never dream of exposing their daughters to the stigma of not being circumcised, and, consequently, not socially accepted (not even well-educated Kisii women). It is an accepted fact that the purpose of circumcision is for women not to become "loose". No husband would put up with a loose woman. It is also an accepted fact that husbands are not expected to "control" themselves. - So husbands "roam about", and all wives have to put up with this.

+) Traditionally, circumcision was a "rite de passage", preparing young women for marriage. Grandmothers would teach the young women and tell them about their duties when they got married. After circumcision the young women could not any longer stay under the same roof as their mothers, and they would go to their grandmothers, until they married. Nowadays, the original meaning of this rite has vanished as girls being circumcised now are between 8-12 years old, and not ready to be prepared for marriage.

Women's status and role within the household

Our preliminary data indicate that women do have a clearly defined subordinate role in the household in their subservient role in the household. In their subservient role as wife, no work is too hard for a woman. They continue to be socially defined as having no occupation/ or to be housewives - taking however, the full responsibility of the support of the family.

Women are producing and preparing the food for the family. They sell their vegetables and other produce in the local market and buy necessities such as salt, sugar, matches and paraffin for their earnings. Money for school fees, building funds, school uniforms as well as clothes for themselves and their children are mainly procured by the women. Only very few men (mostly those with a permanent employment) contributed to these expenses.

Men seem to have increasingly withdrawn from their traditional responsibilities and working tasks, and whether they are living together with their families or not, the area of responsibilities for women has expanded considerably. The result is that women participate to a far greater extent in Aagricultural activities, including cultivation of cash crops - on top of their traditional activities. Whether the households are "officially" female headed households or not, most women are increasingly left as sole providers of the needs of their family, and they are very alone in their worries to make ends meet. The myth, however, still exists, that it is the man who is the bread winner.

This pronounced dissolution and dislocation in the sexual division of labour, and consequently in the gender hierarchy where women are increasingly taking over male responsibilities, seem to be leading to a profound break-down of gender roles in the Kisii context. The undermined old family hierarchy has not been replaced by new definitions of sex roles and authority structures, and both genders - in particular men, seem to be in a very insecure position.

This break-down of gender-roles, we shall argue, is having a serious effect on the status and role of women within the household, an

effect, which has generated two contradictory tendencies 1) a regressive change, i.e. an intensified subordination of women, and 2) a progressive change, i.e. a lessened control by males over females, leading to an increasing independence (implying women's control over their own lives). Linked to the regressive tendency, the increasing workload, combined with an increasing number of children and consequently additional mouths to feed, additional worries and burdens are an increased unconcious acceptance of their subordinate role, where no time or energy are left for them to influence and change their situation.

Linked to the progressive tendency, many women seem to be perfectly aware of the fact that care and security will not be provided to them and their children by their husbands, and they are actively engaged in finding new ways - and developing strategies in order to improve their own lives and the lives of their children. They seem to be able to cope with the changed sexual division of labour to a far greater extent than their husbands. Being left on their own to care for their children, some women seem to have developed a toughness and ability to make ends meet, which seems to be completely lacking on the part of their male counterparts.

Women's raising awareness of their role as sole providers, combined with their husbands' difficulty in coping with their changing role can be associated with a strengthening of their status and role within the household, and consequently with greater decision-making power for women. However, it is very obvious, that women do not want an open confrontation with their husbands - very often because they do not want to be beaten up, but they have developed a number of subtle ways to manipulate with their non-cooperative husbands in order to survive with their children.

A possible explanation for the apparent irresponsibility and male apathy which our interviews with both women and men clearly are proving, is that the role of men has actually, during the process of commercialisation, suffered a far severer dislocation than that of women. Shortage of land, smaller and smaller plots, no cattle to take care of, no tribal fights where men had to defend their families, no participation in political discussions and only very limited possibilities for employment have

caused men to drift into a pattern of sporadic work and drunkenness[+)]. It is a well-known fact that alcoholism is causing serious mental complications which often require admission, liver diseases, gastritis etc. - Consequently, on top of all the other problems women have to cope with is the problem of alcoholic husbands. Some of the women interviewed had several scars from pangas on their faces and bodies, and are being beaten up by their drunken husbands several times a week, especially, if they are reluctant to give them sexual access.[**)] Women are expressing over and over, that the minds of their drinking husbands seem to be seriously affected by the changaa. They cannot conduct a normal discussion with the husbands, and they are beaten up for no apparent reason.

<u>Changes in female status and role and the interaction with women's motivation for spacing of births and family planning.</u>

Traditionally, it was assumed that both women and men had a common interest in getting as many children as possible in order to extend social relations, to have extra hands in the field and as a security in old age. In addition, children were considered a blessing, and women were proud of their child bearing function. Through their children women acquired status.

Women still acquire status through their children. A woman who cannot bear children is considered worthless, and infertility is a disaster. However, under the present conditions, where women most often cannot rely on their husbands, where women are left alone with all responsibilities, pregnancies become a burden, and the status they require through their many childbirths is becoming increasingly questionable.

+) A study carried out in 1979 by the Department of Community Health and the Department of Psychiatry, Nairobi, confirms that Kisii is one of the areas in Kenya with the most serious abuse of alcohol (East African Medical Journal, Vol.56, No.12, Dec. 1979). It is mainly the distilled alcohol (changaa) which is consumed, either alone or in combination with the brewed type (busaa). The concentration of alcohol in busaa is relatively low, 3-5%, whereas that of changaa is about 10 times higher on more. The distilled changaa is gradually replacing the busaa, which has completely changed the drinking pattern and resulted in a serious increase in alcoholism in Kisii. The findings also confirms that one of the main reasons given for drinking are worries and boredom, blamed on lack of something to do.

**) In one of the areas where in-depth studies are being carried out - 150 men out of 200 are estimated to be regular changaa consumers. Out of these 150, 100 are faced with serious drinking problems while 50 of them are to be considered as pure alcoholics. In the same area, 10-15 households out of 200 are distilling and selling changaa.

At this stage in our research, it is not yet possible to conclude to what extent changes in female status and role are acting as potentials or barriers for women to space their children and use family planning. However, it is a fact, that there is a close relationship between women's motivation for family planning and changes in their status and role.

While some women (in particular where no bride price has been paid) are very concerned about producing children in order to make themselves socially accepted as the mother of many children - which again would create a social pressure on the husband to take care of wife and children - other women are very well aware of the fact that many children will not add to their status, but rather increase their responsibilities. In addition,they have also acquired a self confidence, which is not immediately apparent on the surface, but which, as it turned out during our lengthy discussions, manifested itself in the fact that, even if their husbands were not willing to agree/or they had never discussed the question, some women have over several years secretly made several attempts to space their children and have actually been using family planning without their husbands' knowledge. A few women had even had tubarligation without their husband's knowledge. According to the law, women who want to be sterilised must have their husband's signature. However, several women interviewed admitted that they had taken their brothers to the hospital and they had given their signature, pretending that they were the husband.

However, whether female status and role have been submitted to either regressive or progressive changes, our data so far indicate, that women's fertility patterns are being affected by these changes.

As to the regressive changes they were manifested in a tremendous burden of work and responsibilities which left some women with energy only for the daily struggle for survival of themselves and their children, and with no energy to think in terms of planning their future, f.ex. by spacing or stopping their continuous pregnancies. Under pressure from their husbands they seemed to have accepted the fact that "all eggs in them should be used".

This regressive change, it was observed, does not have the same effect on all women. Some women, out of dispair and at the same time aware of the fact that they could simply not handle more children on their own had turned to family planning. This means that the regressive change had turned into a potential as far as motivation for and use of family planning are concerned, and these women were, in spite of the fact that they were submitted to the same conditions as the ones above of a different category.

A third category of women are the ones, who in spite of increased work-load and hardship have succeeded in obtaining a self confidence and self respect. Being aware of the fact that they had to adopt new strategies to survive they were also aware of the fact that it was necessary for them to control their fertility. This can be associated with a progressive change. When one of our interviewees belonging to this third category was asked,"What about your husband, will he agree to you using family planning?" her answer was, "no, but what can be done"! She did not intend to tell him. When again she was confronted with the question,"What will happen when he discovers that you don't get pregnant any more?" her answer was the following: "I shall just shrug my shoulders and say, how can I know. Perhaps you are not able to make me pregnant any more because you drink too much." This woman was twenty five years old, had only attended school until standard five and had just given birth to her 4th child. She had never had her period between pregnancies, and had become pregnant while breastfeeding, when her children were only a few months old. In spite of the fact that her husband had beaten her up several times, even during her pregnancies, she was not at all afraid of him. She had through the past years of hardship developed a toughness and an ability to cope with her situation.

Barriers to women's use of family planning: Husbands' attitude

In spite of recognisable potentials which may act as motivating factors as to women's use of family planning, women are, however, faced with a number of factors which are creating serious barriers for them.

According to women, the attitude of most men to family planning is rather synonimous: they do not share their wives' desire to limit childbirths, they are not concerned about the future to their children,

they are not thinking in terms of planning, but they want their wives to go on producing children. In addition, they want their wives to go on producing children. In addition, men - according to their wives - consider family planning a threat. Husbands become very suspicious if their wives want to use family planning. They link any use of contraceptive methods to their wives' desire to be unfaithful to them, and they even accuse their wives of wanting to become prostitutes. Consequently, family planning is an issue which is not easily discussed between husband and wife. To take up the issue of family planning requires a high degree of confidence between the spouses. This, however, seems to exist only in a very few cases. As a result - many couples just go on producing children, without ever discussing how many children they can actually manage. Even in the few cases where actually both husbands and wives had realised that they could not bear the economic burden of additional children, the subject was not taken up, and no communication about the worries that both husbands and wives felt took place.

A classical example of this situation we found in a household, where the wife just before our arrival had given birth to her ninth child - which was also her ninth son. She was in a state of dispair. She had been so tired and weak during her last pregnancies. However, she felt compelled to go on producing, because she only got sons, and her husband also wanted daughters. She wanted so much "to be done completely". Outside the hut we found her husband and started up, very cautiously, a discussion of much land he had, and how he viewed the future of all his sons. To our surprise the husband burst out with his dispair. How could he manage 9 sons when he only had 3 acres of land! - However, he was convinced that his wife wanted to go on producing until she got some daughters. He wanted her to go for family planning, however, he did not dare to mention it because she might then think that he wanted to take a second wife.

In the above example there are two other sets of barriers which act as hindrance for women's motivation for using family planning. The first one is linked to the sex of children. As a matter of fact, most women in our sample seem to produce more girls than boys, and we have often met the problem that women had no desire at all to limit their childbirths until they had at least 2-3 boys. Having produced f.ex. 5 girls and 1 boy they had no intention of starting to space their children or stopping to give birth, on the contrary, they wanted to continue.

The second set of barriers from the above example is that if women feel that their husbands are pressing them for more children, they are afraid of refusing, fearing that husbands would then take a second wife, or if bride price is not paid then threaten to send their wives back home-together with their children. In that case women give up refusing, because they feel that they have no other alternative. Going back home would mean that a woman and her children would have to live on the land of her parents and share a meagre living with them, and with the parents hoping that she would find another husband or she would become a prostitute to support her children. In the few cases where women with a number of children do find a second husband, this husband would expect the women to produce his children, so women would in any case end up in the same situation whether they gave in for the pressured from the first husband or not, unless they stayed at the mercy of their parents.

MEN AND FAMILY PLANNING

Linked to the fact that focus for our research among others is to establish an understanding of women's changing status and role within the household and consequently also the power relations between men and women - combined with the fact that men and their attitude to family planning seem to create a major barrier for women's motivation for family planning, the importance of conducting research on men was recognised early in the study.

Men, who have the role/and consider themselves as the decision-maker as well as the head of the ohousehold, have been totally neglected in all matters related to family planning until very recently, and family planning was considered to be a matter which only concerned women. If it had been recognised at an earlier stage in the promotion of the idear of birth spacing and family planning this may have had as a result that these issues were surrounded with fewer tabooes, and a more open dialogue could have taken place between women and men. Consequently, research on knowledge, attitudes, practice and expectations has been directed towards women, and men have been left out.

In the above attempt to make a preliminary analysis of data collected, we are relying on information collected through our research on women. As mentioned, most men seem to be opposed to family planning -

according to their wives - even though the issue of family is not discussed in a vast number of households. Approaching men with identical questions those given to women (often wives to the men), - they seemed less opposed - at least - apparently - than their wives expressed. - It is extremely difficult to judge whether we can rely on husbands evidence or not, when the evidence given by their wives are in most cases in total contradiction with that of their husband.

However, to start with we can conclude that we had not expected the apparent openness and interest that men expressed during our interviews. We have very often experienced in our interviews with women that we touch on a subject of extreme importance when we speak of their increasing workloads and the burden of pregnancies, family planning etc., and they feel relieved to be able to talk about themselves and their problems. On the other hand, some women are very reluctant when interviewed. As to men a vast number of men seem to burst out with their problems when we approach them with our questions - whether they are sober or not, and they do not seem to be reluctant to answer any of our questions. Whether some men are trying to give us the impression that they are aware that they cannot afford to have more children, that they have not enough land, that they are worried about the future of their children and that they are willing to cooperate with their wives in spacing or limiting childbirths - and in fact they are not at all prepared to do so - cannot be deduced. However, in a few cases where the interviewing has been carried out over a long period of time, and a follow-up was made, a serious discussion was taken up between husbands and wives, and the wives are now practicing family planning. But whether or not men are telling us the truth, our interviews with men clearly indicate that they feel very insecure, confused and frustrated in their present role, which is increasingly loosing its foundation. It is also a fact that drinking for the majority of men is the only way to avoid facing problems, and therefore drinking becomes a major activity for them. A number of men have expressed their jealousy towards women who are engaged in women's group activities and wish that similar groups could be organised for men in various areas.

When it comes to the question of family planning it is evident that inspite of increasing information over the radio about the growing population and the necessity of planning families, men's knowledge on

family planning is extremely limited; inspite of the fact that they have heard of different contraceptive methods, they are extremely ignorant. However, they seem very eager to get more information, and we are constantly approached by men who are asking us to teach them about the different methods. On the other hand, a number of interviews with husbands and wives, separately and together, indicate that many men in their changed role feel squeezed out and try to exercise their authority and power through violence, by abusing their wives sexually and by coming up with different threats if their wives refuse them, or if they do not do what they are told to. It is also a fact, that many men in their changed role feel that the only hope for them is to get a vast number of children, because "perhaps one of them will one day become a big man - even the president of Kenya"!

Potentials and barriers for women's motivation for family planning related to child labour and costs of children

The weakening of kinship relations which we find in Kisii and the breaking down of mutual aid relationships may in theory have increased the dependence on children as sources of labour and of support of parents in old age, and this development, it could be argued, may act as stimulus to increased fertility. In the studies by Kongstaad and Monsted in the 70s the need of child labour is stressed as an encouragement to increased fertility in Kisii. A part from the fact that children traditionally were vastly used as extra hands in the field, this is not a new argument. In addition, the findings by the above authors seem to be closely linked to the boom in cash crops, especially coffee was in the market. Consequently, there was an increased labour requirement, and children were an economic asset as extra hands in the fields*).

Our findings indicate that child labour still constitutes an important factor, primarily as help to fetch water, finding firewood and taking care of younger sisters and borthers. However, with the economic problems in Kisii, decrease in the market for coffee, as well as increase ing pressure on land, and on top of this, the tremendous burden that school fees constitute - the tendency seems to be that the economic burden of children is a major concern. Consequently, the economic asset that children formerly represented is now being replaced by economic burdens in relation to children, which, in the Kisii context, we shall argue, may be acting as stimulus to decreased fertility.

This argument is being supported by Caldwell in his latest work on fertility decline, where he restates his wealth-flow theory, arguing that when wealth flows from children to parents, then high fertility becomes advantageous and, consequently, rational. When such flows are reversed then fertility falls, and a new rationality becomes dominant.[+)]

Side-effects, and the barriers that they represent for women's motivation for use of contraceptives

All women interviewed know that they can space their births, and most women also know that they can stop giving births. Exact knowledge on different methods is very rare[++)], and sometimes women are under the impression that "family planning" is synonymous with sterilisation. The methods most known are pills and tubarligation.

However the notion of side-effects is very much discussed by both women and men. Everybody has heard of numerous types of side-effects, and a predominant reason for women not to use family planning is referred to side-effects. Side-effects are also used by many men as an excuse not to agree to let their wives use contraceptives[+++)].

It is a well-known fact that contraceptives can cause various types of side-effects. Common problems of women who are receiving oral contraceptives are depression, headaches, nausea and vomiting, weight gain or weight loss, spotting and bleeding between periods, palpations of heart, loss of libido, etc. etc. However, it is also a fact that many of these problems can also be caused by other factors. Women, though, according to the medical staff at the health facilities in Kisii tend to blame any sign of illness or discomfort on the contraceptive method, if they are FP-users. One of the most common complaints by FP-users is that they have back-ache,

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+) This argument is being supported by Constantina Safilios Rotchild who is in the process of carrying out a study on women's fertility patterns in Kakamega and in Nyeri. In Kakamega it is argued, fertility is high because of the need for child labour while fertility is declining in Nyeri, because of the costs of children.

++) 60% of all health facilities in Kisii are operated by Catholic Missions, and no information on family planning is given, when women are attending ante natal clinics, apart from Billings method/ "natural" family planning. The "natural" method can, according to the Catholic church, only be practices when there is love and trust between spouses. As this seems to be an almost non-existant phenomenon in the Kisii context, this method does not seem to have many chances, (apart from the fact that even if the method has been taught over a period of one year, it is not sure that the method has been learnt).

+++) Attending a Baraza in the village of Marani an active discussion took place about family planning. The audience consisted of 209 men and 32 women. One woman had the floor once, and she accused men for preventing their wives from using FP. The rest of the discussion was undertaken by men whose main argument for not letting their wives go for FP was that it made them to become weak and could not work in the shamba.

caused by the contraceptive method. They do not link their backache to their hard work in the shamba. This statement is not made to minimise the serious side effects that the various methods do have on many women, but the intention is to draw the attention to the fact that whether the notion of side-effects is real or psychological - the notion is there, and it presents a serious barrier for women.

Side-effects have never been seriously dealt with in the launching of family planning in Kenya, however, with the acknowledged need for women to space their birth and limit their pregnancies this issue need to be discussed in detail, and proper information to women needs to be given. Pills f.ex. are the most common contraceptive for women in Kenya. However, with pills there is also a vast misuse because of insufficient information. Several women in our sample are complaining about irregular bleedings between periods. When questioned about their practice in their use of pills they admitted, that when husbands were away for some days they stopped taking their pills. This is a typical case of misuse, which is causing irregular bleedings. However, if these women had been instructed properly in the use of pills, this type of side-effect which is very common could have been avoided.

Related to this is also the fact that women do not know that several types of pills are available. Therefore, when some of the women we interviewed had experienced headache of nausea and vomiting they simply stopped to take the pills for a few days - or they stopped completely, because they felt too uncomfortable. A few of those who had stopped to take the pills over a few days had become pregnant, and thus rumours about pills not being safe can easily be created.

As to the coil which is only used to a very limited extent, women are very afraid of using it because they have heard that it disappears in the body and goes to the head. Rumours also tell that women are not safe with a coil, there are many examples of women who got pregnant with a coil. These rumours are not untrue, i.e. coils do not disappear in the body and go to the head, but they do fall out if they are not inserted properly and have the proper size, and if women do not notice that their coil has fallen out they do get pregnant. In order to correct

these "side-effects", the family planning personnel must be approached and more instructions must be given, in order for them to give proper information to their clients.

Along with the fears of side-effects are the fear of bewitching, which is mentioned over and over by both women and men. If it should be known publicly that a woman is using contraceptives, and purposely limiting her births, she might risk that her children might be bewitched (by some unknown person), and that they might die, become epileptics, blind or might even end up as criminals. In spite of the fact that no women nor men interviewed have been able to come up with any concrete example of children being bewitched because the mother was practicing family planning - the belief still exists and seem to influence many.

Availability and quality of Family Planning Services in Kisii District

In spite of the fact that Kisii with a population very soon arriving at 1.5 mill. a population density of up to 600 per square km in certain parts of Kisii and with an increasing birth rate of 8% per year (national birth rate = 4%) the availability of family planning services is far from sufficient in addition to the fact that the quality of the services (apart from a few) is poor. Having discussed, above, the various barriers for women's motivation for use of family planning it is obvious that women are faced with a number of factors that are acting as serious hindrances. In addition to these the lack of adequate family planning services is creating another serious barrier. If family planning services are inadequate and not available, how can women be expected to make use of the services?

Our research so far indicate that among reproductive women many of them are in fact potential users, however, if this need cannot be met and taken care of this potential is lost. At this point we shall not go into detail about the family planning services. However, it should be pointed out that the users of family planning constitute an insignificant small number (cf. table 1 which indicate family planning figures for Kisii District in 1984), which it shall be argued is due to lack of availability of services, lack of adequate information on contraceptive methods, and

unqualified and unmotivated family planning staff. Efforts are being made from the government and from various other organisations in order to improve information on family planning, however, these efforts still seem like a drop in the ocean in the Kisii context.

According to statistics from Kisii General Hospital, 50% of all admittances are induced abortions. This figure shows that unwanted pregnancies are becoming an increasingly common and serious problem, which does need to be taken care of. It is not easy to break down barriers at the household level, but if efforts are made from the family planning service side to reach women who are potential users the chance of turning them into users is there.

In the overwhelming number of abortions school girls and unmarried women are constituting a considerable number. This number could be reduced if the FP- personnel at the health facilities were instructed not to let their own attitudes influence their professional responsibility, i.e. to help those, who have the courage to come and ask for contraceptives. Having interviewed the FP-staff at several health facilities in Kisii District, it is a fact that they do not want to encourage teen-agers and unmarried women to immoral behaviour. As a result, this group of potential users are turned away with foam tablets and condoms which their partners are not interested in using.

Some of the women in our sample, who are potential users have been turned away for different reasons, such as mis-use of pills (insufficient instructions?), wheredpills were not taken regularly, or when the users had given out some pills to a friend, to "help" her. Irritated by their clients, health staff admit that in order to "teach" their clients, - they are turned away with foam tablets and condoms. Other reasons for women to be turned away are f.ex. dirty clothes or coming too late in the afternoon (f. ex. at 3 p.m. - when the services close at 5 p.m.)!

Another way of loosing potential users is the existant requirement that family planning (apart from condoms and foam tablets) can only be given to women who come during their period. Most women do not know about this requirement and many become pregnant before they see their

TABLE 1

FAMILY PLANNING ACCEPTANCE IN KISII DISTRICT IN 1984 (Data from the MINISTRY OF HEALTH just processed not yet officially available) (obtained Sept. 1985)

Report rate	1st visit	Revisit	Acceptor	Pill	IUD	Injection	Other+)	Operating Units
January to March:								
51%	223	863	223	160	43	11	9	20
April to June:								
40%	470	783	470	295	147	15	10	22
July to Sept.:								
43%	405	1394	405	295	77	5	28	22
October to December:								
48%	421	1092	421	219	147	25	30	20
Totals:	1519	3132	1519	969	414	56	77	

+) Most often condoms and foam tablets. Only 1 diaphragm was given during the whole year of 1984 at Kisii Hospital (NB. No varinal gel to go with diaphragm available - but also this method it is said does not appeal to women in Kisii).

period[+)]. Even if a woman is supplied with foam tablets and condoms she might still get pregnant in the case where her husband refuses to cooperate, or in particular if he has not agreed to her use of family planning.

Breast-feeding mothers are equally required to have started menstruating again after delivery in order to get pills or coils. This creates a major problem for them, as it varies from woman to woman when her period starts. Some women start their period 2-3 months after delivery, while others start 2 years later. With the requirement of being in menstruation many women get pregnant again without ever having seen their period.[++)]

CONCLUSION

The above discussion, which is based on preliminary findings is a tentative attempt to elucidate and analyse factors which encourage or discourage the use of family planning services by women. Data collected so far reveal that there are serious barriers both linked to the family planning services as well as to aspects external to the services. A main objective of this paper, however, is to establish that our research so far indicate that an increasing number of women seem to have, an increasing number of reasons for wanting to limit their pregnancies, - and that, in fact, many women may be considered as potential users of family planning.

It should also be stressed, though, that comparing the number of potential users with the number of actual users of family planning, there is a serious discrepancy. This fact leads to the conclusion that there is a big step from women's desire in theory to plan their families and to their conscious step towards trying to change their fertility pattern in practice. On the other hand it should be emphasised that women cannot limit their pregnancies alone. Women are faced with numerous barriers which it may take generations to break through. However, if women within

[+)] The requirement of being in menstruation in order to be given contraceptives does not exist in European countries.

[++)] Pills for breast-feeding mothers have not been allowed over the past year because of fears of side-effects on their children. However, the "mini" - pill has now been included in the family planning kits, and pills are thus again available for breast-feeding mothers, provided their menstruation has started.

a short period of time do not have access to information on family planning, a wide distribution of family planning services and highly qualified family planning staff, fertility patterns cannot be expected to decline in the near future.

Looking at the historic development in the Western world, it was the economic and technological take-off which stabilised population figures. Consequently, it can be argued that the only answer to population growth is socio-economic development. However, considering the problems that women are faced within Kisii, short term answers must be found. Family planning is the only short term measure known which can free women from frequent childbirths. Therefore, in order for women to be able to participate in a long term development which will improve their status and role, not only within the household, but also in society, it becomes paramount to emphasise efforts which will make it possible for women to be able to control their fertility.

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